SAMARITANS Scotland

Self-harm digital conference, June 2021

Harm Prevention and Harm Reduction Challenge Group

Online whiteboard screens

Participants in pairs, in breakout rooms, answer the question "What do you think are the key issues about prevention of self-harm and harm reduction, and any tension between the two?"

Pair 1

Links or not to suicide risk

Will we be seen as playing catch up with the work around suicide rather than manage it as a distinct issue?

Attitudes when seeking help

people with BPD using self-harm and pitching up to A&E but treatment is often appalling

stigma

Too many people get a poor response

Are we too far ahead of the public in the sector - e.g. we are comfortable with drug misuse approaches and could just apply

are the public and politicians ready to handle the risk

Professionals not always best equipped to support those who self-harm

Apply principles of time, space and complassion?

Who runs it in SG? Too many cooks? Who is in control?

Prevention can feel so vague and huge people are overwhelemed and don't act

Prevention starts with children - but CAMHS a mess and major CYP wellbeing issues

What are the implications (training / rregulation / tie) for registered profs

funding

Pair 2

remove stigma and allow open conversation

Involving lived experience in each stage of organisational development

Education for clinicians on harm reduction

Supporting clinicians to do more postive risk taking

Developing a compassion focused response

Practical support in the community for speed of access

Encourage emotional health in young people- workshops in schools

Pair 3

not binary - not versus

striking a balance

do we have infrastructure / support available for people if encouraging them to come forward?

creating safe spaces / places

safe self-harm zones /spaces

policy may be controversial

changing culture / staff attitudes

CAMHS already overloaded

ensuring services can cope

fear of being prevented from self-harm?

people concealing self-harm

enabling people to feel comfortable / confident in coming forwrd, asking for help?

training for frontlines services - to understand, to respond appropriately

importance of all different agencies, services pulling together - in prison setting but more widely

stigma

bullying

control?

how do we empower young people so they can control self-harm?

different policies / responses compared to suicide prevention - not interchangeable

impact of covid in increasing need?

Pair 4

how to tackle harm reduction without making someone inadvertently worse or at higher risk

lack of tolerance towards self harm by medical professionals and general stigma

how to balance digital versus face to face services and know what is most helpful to people who SH

how to know who to target for prevention?

Voting on which of these issues to discuss in 1st workshop

Listening to LE voice
people to control for themselves - informed choice by individuals

services are overloaded (specially for YP) And prevention feels vauge - who to target?

suicide link?
playing catchup?
NOT interchangeable

services and politicians ready for risk?
What about regulated professionals?
If public don't like controvoserial policies like safe zones

who runs it? too many cooks

Stigma and misconceptoins

Small-group discussions, in breakout rooms, on the two most popular themes:

"People taking taking control" - listening to voices of lived experience, informed choice by individuals (one group)

"Stigma and misconceptions" (two groups)

People taking control

Listening to voices of Lived Experience, empowering people to take control, informed choice by individuals

Staff attitude and staff culture

Approaching self-harm as suicide prevention, puts undue responsibility on staff

Balance between giving people choice and maintaining security for staff

Again, balance between allowing choice and keeping people safe

Training and raising awareness really important

security issues - how far do we allow people to self-harm?

Risk appetite - low-risk culture among professional staff.

The individual is actively making a choice - though they might not feel they have a choice. Supporting individual to realise that they're agents of change in their own lives.

Acknowledging that the individual is making a choice - they're an agent of change.

A lot of overlap with the Suicide Prevention Group - that time and compassion approach seems to work well and comes up a lot.

Services need to work better together to help things move forward

People should be permitted to self-harm - it's a coping mechanism.

Listen to what they want; and tailor approach to them

Individual should feel heard and be part of a conversation

Needs to be a conversation between two people - equal power dynamic

Trust and truth in that conversation - building a relationshop

If people feel heard, they will be happier with the outcome

The conversation should be a choice for the individual - who they talk to, when

At the heart of the balance between prevention and reduction there's CONVERSATION.

Both people are active listeners

Conversations - truth, trust, and equality

harm reduction does not mean you don't pay attention to prevention, eg for YP

Reduction over prevention

Stigma and misconceptions

connections between agencies

people who self-harm totally misplaced in A&E

police and A&E is last place they want to be - but need to make sure stigma gone

time , space and compassion principles re suicidal risk - same principles here?

someone who self harms in prison being an immediate suicide risk - how to reduce this - staff training?

where is the right place for support?

missed opportunities before crisis point

intervening earlier in journey

better public awareness - equips families, friends to support others

workforce attitudes

staff training across agencies & servicies

importance of training across frontline services

need to listen to ppl sooner

knowing how to help

specific services but eaiser, accessible routes into these

Stigma and misconceptions

Emergency services are naturally risk-averse. Lots of internalised mental health stigma - re decision to treat at home or take to hospital We're working on it, but our fears around self-harm feed into patient journey.

unhelpful narratives around self-harm

clinically, unless you're trained to manage risk, you'll lean to prevention. Treating self-harm is sacry as a clinician. Makes it look like 'I"m not doing my job if they go on self-harming'. Professionals are risk-avoidant

attitudes: people being dismissed as attention-seeking or not deserving of treatment as other injuries eg rugby THIs prevents people from seeking help, then it's difficult to do either reduction or prevention

what happens when something bad happens - an investigation - professionals live with anxiety

self-harm, it's all ages & genders, can be at transition point. So careful any policy is for all demographics

If you ask public, they think it's only teenage girls. There's hidden self-harmers

self-harm is so complex, so many reasons to do it. Prevention for YP in schools is one thing. HOW do you begin to address prevention for older ppl?
How often to clinicians ASK questions about self-harm?

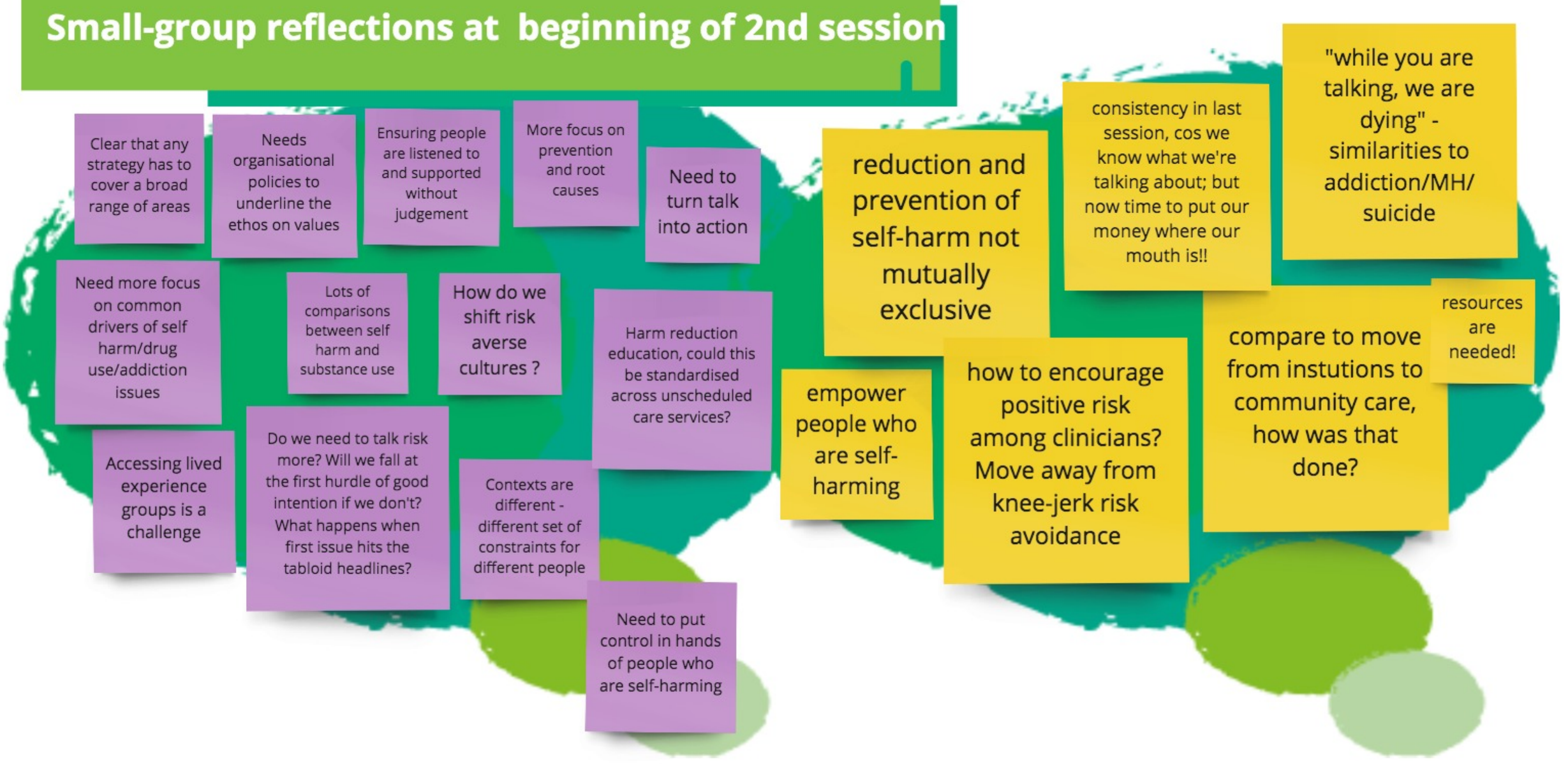
People with lived experience know they need a range of services - it's not one size fits all

people are relcutant to seek help cos of the stigma, more than risk-averseness of professionals

self-harm is a coping mechanism, if they don't have it, what coping mechanism do they have?? It becomes part of a person's identity?

Participants' closing thoughts at end of 1st Harm Prevention/Reduction workshop

Small-group reflections at beginning of 2nd session



Selection of key issues

How can services strike the right balance between Harm Prevention and Harm Reduction?

CHOICE/CONTROL
Prevention is not TELLING people to stop self-harming

HOW do services "allow" people to make their own choice and take their own risks, while being compassionate and person-centred?
What are the PRINCIPLES?

INNOVATION
There are INNOVATIVE approaches that combine harm-reduction and harm-prevention (eg safe zones).

WHAT would make it easier for regulated professionals to innovate? Despite the risks?
What are the PRINCIPLES?

STIGMA/RISK
Harm reduction approach is scary for services which are risk-averse and have internalised stigma about self-harm

HOW can services SHARE the risk with the person?
What are the PRINCIPLES?

OVERLOADED SERVICES
Existing services are overloaded.
Most people who self-harm don't seek help from any services.

HOW do we offer harm-reduction &/or harm-prevention to the people services DON'T reach?

How do we join up services?

What are the PRINCIPLES?

Full Challenge Group
discusses the three selected issues:
Stigma/Risk
Choice/Control
Overloaded services

STIGMA/RISK

Harm reduction approach is scary for services which are risk-averse and have internalised stigma about self-harm

training for professional serviices

need to have training for professional services and a discussion to see how far they can go with risk

Practitioners who are comfortable & confident speaking about self-harm, through training & support

Compare to addictions: look at the causes intentions, the trauma behind the behaviour. Harm reduction recognises the issues. Relationship is born as the harm is reduced. We learned addition approach of the past was wrong and was top-down. Now we are full-on harm-reduction and the principles are the same. Nothing about me without me. Where is the person right now. Trauma informed. Risk aversion is peternalisic. We need co-production

Use a model of person centres and trauma informed care, where the personhood of all is at the centre.

internal stigma of the person self harming needs to be considered

Stigma is dynamic in that it changes, from tome to time even within services and people. In my view it is largely that self harm is a scary subject and even 'experts' are out of their comfort zone when faced with this. Let's help make it less scary?

Clinicians can often see Deliberate Self Harm as their own failure, that their support "isn't working". Fear of families not trusting the process if their loved one self harms

Risk aversion is often based on the fear of something going wrong and being sued, need to remove this concern so people are comfortable discussing levels of risk and allowing the individual to take the lead

people need to understand why people self-harm, it's not necessarily with suicidal intent. INTENTION is crucial . That stops services feel they are failing. Stops them over-dramatising.

Believe vulnerable people when they talk about their thoughts and feelings

Trauma understanding through ACES . Complexity is normal and need incremental steps

Foucs on stories - show people the difference it can make!

Clear expectations of good practice

this is effective communication - when it's warts and all !

prevention should start way back in childhood

this can start very young (nursery) we all need to know life is challenging and stress-relef tools

shift from fixing to supporting

Shift thinking from risk management to risk enabling

Relational working

Treat people as adults, treat thier reasons as valid. Reciprocicy. Equal relationship

risk managment is about protecting the institution, not the person. That need to change

can share a risk by actively involving rather than instructing

enable positive risk management

Joined-up approach

End the fixing mode
Take the journey with the person

Staff have duty of care so staff are risk averse

the prison service have death in custody processes (Fatal Accident Inquiries being just one) these cause similar stress and anxiety for our staff.

We are aiming to work with staff to reduce any stigma from attending incidents of the same person on numerous occasions, we need to better understand Self Harm and never make judgement. This applies to Tri-Service and we are working together for new training and make use of resources which are available i.e. NHS NES training resources. No need to reinvent any wheels when the resources are there

SPS is modifying NES training

how to define duty of care? Is harm reduction not care?

CHOICE/CONTROL

How do services "allow" people to make their own choice and take their own risks?

It's not about ALLOWING

the principle of self - determination should be part of how we manage this

If you are going to be truly compassionate and person centred it means supporting the individual to make their own choices and take their own risk

exploring the risks with the person, not telling or assuming that they know

a non judgemental conversation between equals about SH and the possible consequences

Choice. Choice between good things. Not least worst option. Worst worst...or nothing at all

Choice must be informed- so 'information' (which must be accessible, understandable, and pertinent) is necessary to allow choice

Informed choice, make sure I have the information I need to make the right choice for me.

does self-harm stem from lack of choice - lack of other options / seems like only option?

people need to have the choice to self-harm, because it serves a purpose, but we should work to broaden their emotional toolkit, so they have other options

from my personal experience, the key thing is open and honest conversations early on, when person does have the capacity , that if the time comes - retrospective understanding. I hated treatment forced on me but I respect the decision. Principle is involving the person!!!

Do we have capacity / deviersity in the support system to offer choice

How much is it the job of those who intervene to help people see different choices?

Should this sort of collaborative work depend on the individuals involved (service user and professional)? As trained professionals we have a duty of care to ensure we are mindful of the sometimes fluctuating nature of capacity and have th agreed from the outset. Challenging!!

how much is the fear of takin risk based on the monster under the bed feeling, and how much in real concersn about regulation etc?

We can't expect people delivering services (in broadest sense) to offer choice in self-harming if political and civic dialogue not begun - needs a bold step to bring opinion along at least a little or practitioners very exposed.

Needs a solution-focused approach, not starting with why we can't do it.

Mindful of other ppl involved in decision making process - there's the 'patient' and 'clinician' but also families, parents, peers who may have different perspectives, may influence choices

is this about overloaded services?

some self-harm is more palatable, some is really shocking to service-provider. We need assistance for adult and child protection.

it's not one-size-fits all . Need flexibility to respond and to keep people safe

capacity problem - we need robust safeguarding in place

practitioners know what good practice looks like & what is expected of them in their practice

how do we build the confidence in the general public to assert the right to choose?

OVERLOADED SERVICES

HOW do we offer harm-reduction &/or harm-prevention to the people services DON'T reach? How do we join up services?

importance of coproducing /shared ownersip of services

principle of "no wrong door" should be applied

Make sure info on access to services shows multiple demographics (and train those offering support in equality and inclusion approaches. Help should be avialable to everyone in ways that make sennse to them.

People often describe being passed 'pillar to post' when first trying to access help, which puts them off getting help. We must make sure people are properly sign posted and helped to get to the right place rather than turned away or shoved on another waiting list.

Enable a societal understanding of Self-Harm. So, no matter who I speak to, they can talk to me about SH. i.e. mental health 1st aid

open training opportunities to all and not just MH services

capacity building across the whole system of support - not just health services, but schools, community services, families, online

Having options- ideally a range of services, statuatory/ non-stat, digital, in person, etc

engaging with informal support networks / online forums etc - meeting ppl where they are

policy and service should join up

a GIRFEC type model for vulnerability

GIRFEC stands for Getting It Right for Every Child

Trying to reach those people who don't or can't seek help is probably acting too late. A proactive approach to building emotional capital, emotional regulation and distress tolerance in schools and families may be more valuable to people than a reactive, treatment based approach.

Scottish Government must join up their various departments in the first instance and take ownership of joining up all the services. We can only achieve what we want by working together and learning from each other. There are many best practice resources in parts of the country which are not shared and this needs to change. This needs to be done quickly to create a positive correlation of all services achieving a Whole System Pathway.

need to look beyond the traditional mental health services especially for those working with Children and young people services within communities delivering youth work for example could play a key role

need to change societal views in future generations. Decision-makers need to look beyond their term. Not a quick fix. To eliminate stigma and self-stigma. Open conversations. New S word - no longer sex that is stigmatised, we can talk about sex. But Suicide and Self-harm are not spoken about.

multi-disciplinary forum, does this exist in MH, before crisis point??

More joined-up services before crisis, involving the person, would help

Education

Lived experience navigators.

examples of lived experience "warts and all"

Participants' closing thoughts at the end of 2nd Harm Prevention/Reduction workshop

an amazing week of diverse and shared thoughts from an amazing group. SG - you have a wealth of expertise and drive to draw on.

It's time to stop talking and start doing

Agree!

These workshops have been open, candid and honest and a huge thank you to everyone for their thoughts and ideas. If we call continue to work together, to talk to each other, to listen and learn we can only move forward.

Thank you for raising thie issue. Great to meet with everyone and have new connections.

its been amazing to hear everyones differing opinions yet that common goal.

A healed femur is the mark of a civilised society... paraphrasing Margaret Mead

Have added this to the discussion re the writing of the new National Youth Work Strategy. I'm one of the people leading on writing the health & wellbeing section.

enjoyed the format and the discussions

thanks for being great people to work with and raising points I hadn't thought about - a deeper understanding of issues for different organisations

Thank you so much for working towards making this a priority

Thank you all for your thoughts and insights over the last two sessions. Thank you for your great job facilitating!

Thanks for making this a really geat way to share aspirations